SERFF Tracking Number:	*UHLC-125885580*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*40786*
Company Tracking Number:	*VPOLCOC.SR.08.AR*		
TOI:	*H20G Group Health - Vision*	*Sub-TOI:*	*H20G.000 Health - Vision*
Product Name:	*Vision Group Blanket Forms*		
Project Name/Number:	*/*		

Filing at a Glance

Company: United HealthCare Insurance Company

Product Name: Vision Group Blanket Forms	SERFF Tr Num: UHLC-125885580	State: ArkansasLH
TOI: H20G Group Health - Vision	SERFF Status: Closed	State Tr Num: 40786
Sub-TOI: H20G.000 Health - Vision	Co Tr Num: VPOLCOC.SR.08.AR	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Authors: Jayne Jackowski, Lynn Kaisershot	Disposition Date: 11/06/2008
	Date Submitted: 11/06/2008	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Large
Overall Rate Impact:	Group Market Type: Blanket
Filing Status Changed: 11/06/2008	
State Status Changed: 11/06/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Group Blanket Vision forms filing.

Company and Contact

Filing Contact Information

Jayne Jackowski, Senior Specialty Product	Jayne.Jackowski@eams.com

SERFF Tracking Number:	*UHLC-125885580*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*40786*
Company Tracking Number:	*VPOLCOC.SR.08.AR*		
TOI:	*H20G Group Health - Vision*	*Sub-TOI:*	*H20G.000 Health - Vision*
Product Name:	*Vision Group Blanket Forms*		
Project Name/Number:	*/*		

Analyst

3100 AMS Blvd.
Green Bay, WI 54313

(920) 661-2234 [Phone]
(920) 661-9861[FAX]

Filing Company Information

United HealthCare Insurance Company	CoCode: 79413	State of Domicile: Connecticut
450 Columbus Boulevard	Group Code: 707	Company Type: Health
PO Box 150450		
Hartford, CT 06115-0450	Group Name:	State ID Number:
(215) 653-8046 ext. [Phone]	FEIN Number: 36-2739571	

SERFF Tracking Number:	*UHLC-125885580*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*40786*
Company Tracking Number:	*VPOLCOC.SR.08.AR*		
TOI:	*H20G Group Health - Vision*	*Sub-TOI:*	*H20G.000 Health - Vision*
Product Name:	*Vision Group Blanket Forms*		
Project Name/Number:	*/*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United HealthCare Insurance Company	$50.00	11/06/2008	23747832

SERFF Tracking Number:	*UHLC-125885580*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*40786*
Company Tracking Number:	*VPOLCOC.SR.08.AR*		
TOI:	*H20G Group Health - Vision*	*Sub-TOI:*	*H20G.000 Health - Vision*
Product Name:	*Vision Group Blanket Forms*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/06/2008	11/06/2008

SERFF Tracking Number:	*UHLC-125885580*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*40786*
Company Tracking Number:	*VPOLCOC.SR.08.AR*		
TOI:	*H20G Group Health - Vision*	*Sub-TOI:*	*H20G.000 Health - Vision*
Product Name:	*Vision Group Blanket Forms*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 11/06/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-125885580*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*40786*
Company Tracking Number:	*VPOLCOC.SR.08.AR*		
TOI:	*H20G Group Health - Vision*	*Sub-TOI:*	*H20G.000 Health - Vision*
Product Name:	*Vision Group Blanket Forms*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Table of Benefits	Approved-Closed	Yes
Form	Vision Care Insurance Policy	Approved-Closed	Yes

SERFF Tracking Number:	*UHLC-125885580*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*40786*
Company Tracking Number:	*VPOLCOC.SR.08.AR*		
TOI:	*H20G Group Health - Vision*	*Sub-TOI:*	*H20G.000 Health - Vision*
Product Name:	*Vision Group Blanket Forms*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: VPOLCOC.SR.08.AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	VTOB.SR.08	Schedule Pages	Table of Benefits	Initial			New Schedule DSCHSR08.pdf
Approved-Closed	VPOLCOC.SR.08.AR	Policy/Contract/Fraternal Certificate	Vision Care Insurance Policy	Initial			VPOLCOC.SR.08.AR.pdf

SCHEDULE OF COVERED DENTAL SERVICES

[1]Include if the Copayment applies after the Deductible is satisfied. [2]Include if applicable when Copayment is shown as a percentage of Eligible Expenses. Delete the categories and Benefit Descriptions and Limitations that are not applicable.

[BENEFIT DESCRIPTION & LIMITATION]	**[NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].]	**[NON-NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].] [[2] The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[DIAGNOSTIC SERVICES]		
[Bacteriologic Cultures] [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Viral Cultures] [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Intraoral Bitewing Radiographs] [Limited to [1] series of films per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Panorex Radiographs] [Limited to [1] [time] per [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Oral/Facial Photographic Images] [Limited to [1] [time] [set of images] per [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Diagnostic Casts] [Limited to [1] [time] per [consecutive] [24 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Extraoral Radiographs]	[0% - 100%]	[0% - 100%]

[BENEFIT DESCRIPTION & LIMITATION]	**[NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].]	**[NON-NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].] [[2] The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[Limited to [1] [film] per [consecutive] [12 months] [calendar year] [Plan Year].]		
[Intraoral - Complete Series (including bitewings)] [Limited to [1] [time] per [consecutive] [60 months] [calendar year] [Plan Year].] [Vertical bitewings can not be billed in conjunction with a complete series.]	[0% - 100%]	[0% - 100%]
[Intraoral Periapical Radiographs] [Limited to [1] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Pulp Vitality Tests] [Limited to [1] [charge] per visit, regardless of how many teeth are tested.]	[0% - 100%]	[0% - 100%]
[Intraoral Occlusal Film] [Limited to [1] [film] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Periodic Oral Evaluation] [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Comprehensive Oral Evaluation] [Limited to [1] [time] per [consecutive] [36 months] [calendar year] [Plan Year] for established patients.] [Not Covered if done in conjunction with other exams.]	[0% - 100%]	[0% - 100%]
[Limited or Detailed Oral	[0% - 100%]	[0% - 100%]

[BENEFIT DESCRIPTION & LIMITATION]	**[NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].]	**[NON-NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].] [[2] The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
Evaluation] [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year.]] [Only [1] exam is Covered per date of service.]		
[Comprehensive Periodontal Evaluation - new or established patient] [Limited to [1] [time] per [consecutive] [36 months] [calendar year] [Plan Year.] [Not Covered if done in conjunction with other exams.]	[0% - 100%]	[0% - 100%]
[Genetic Test for Susceptibility to Oral Diseases] [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Adjunctive Pre-Diagnostic Test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures] [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Decalcification Procedure] [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Tissue Staining] [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]

[BENEFIT DESCRIPTION & LIMITATION]	**[NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].]	**[NON-NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].] [[2] The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[Electron Microscopy - Diagnostic] [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Immunofluorescence] [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Pathology Consultations] [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Other Oral Pathology Procedures, by report] [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Tissue In-Situ Hybridization, including interpretation] [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[PREVENTIVE SERVICES]		
[Dental Prophylaxis] [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].] [Is not Covered in addition to periodontal maintenance.]	[0% - 100%]	[0% - 100%]
[Fluoride Treatments - child] [Limited to Covered Persons under the age of [12] years, and limited to [1] [time] per [consecutive] [12 months]	[0% - 100%]	[0% - 100%]

[BENEFIT DESCRIPTION & LIMITATION]	**[NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].]	**[NON-NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].] [[2] The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[calendar year] [Plan Year].]		
[Sealants] [Limited to Covered Persons under the age of [12] years and [once per first or second permanent molar] every [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Space Maintainers] [Limited to Covered Persons under the age of [12] years, once per [consecutive] [60 months] [calendar year] [Plan Year] [lifetime].] [Benefit includes all adjustments within [6] months of installation.]	[0% - 100%]	[0% - 100%]
[Re-Cement Space Maintainers] [Limited to [1] per [consecutive] [12 months] [calendar year] [Plan Year] [lifetime] after initial insertion.]	[0% - 100%]	[0% - 100%]
[MINOR RESTORATIVE SERVICES]		
[Amalgam Restorations] [Multiple restorations on one surface will be treated as a single filling.] [Limited to [1] [time] per [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Composite Resin Restorations - Anterior] [Multiple restorations on one surface will be treated as a single filling.] [Limited to [1] [time] per [consecutive] [60 months]	[0% - 100%]	[0% - 100%]

[BENEFIT DESCRIPTION & LIMITATION]	**[NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].]	**[NON-NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].] [[2] The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[calendar year] [Plan Year].]		
[Composite Resin Restorations - Posterior] [Multiple restorations on one surface will be treated as a single filling.] [Limited to [1] [time] per [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Gold Foil Restorations] [Multiple restorations on one surface will be treated as a single filling] [Covered on posterior teeth only] [Limited to [1] [time] per [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[ENDODONTICS]		
[Apexification] [Limited to [1] [time] per tooth per lifetime.]	[0% - 100%]	[0% - 100%]
[Apicoectomy and Retrograde Filling] [Limited to [1] [time] per tooth per lifetime.]	[0% - 100%]	[0% - 100%]
[Hemisection] [Limited to [1] [time] per tooth per lifetime.]	[0% - 100%]	[0% - 100%]
[Root Canal Therapy] [Limited to [1] [time] per tooth per lifetime.] [Dentist cannot charge retreatment codes on tooth treated for the first [12 months].]	[0% - 100%]	[0% - 100%]

[BENEFIT DESCRIPTION & LIMITATION]	**[NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].]	**[NON-NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].] [[2] The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[Retreatment of Previous Root Canal Therapy] [Dentist who performed the original root canal should not be reimbursed for the retreatment for the first [12 months].]	[0% - 100%]	[0% - 100%]
[Root Resection/Amputation] [Limited to [1] [time] per tooth per lifetime.]	[0% - 100%]	[0% - 100%]
[Therapeutic Pulpotomy] [Limited to [1] [time] per primary or secondary tooth per lifetime.]	[0% - 100%]	[0% - 100%]
[Pulpal Therapy (resorbable filling) - Anterior or Posterior, Primary Tooth (excluding final restoration)] [Limited to [1] per tooth per lifetime.] [Covered for anterior or posterior teeth only.]	[0% - 100%]	[0% - 100%]
[Pulp Caps - Direct/Indirect – excluding final restoration] [Not Covered if utilized solely as a liner or base underneath a restoration.]	[0% - 100%]	[0% - 100%]
[Pulpal Debridement, Primary and Permanent Teeth] [Not Covered if done by same dentist performing definitive root canal therapy.]	[0% - 100%]	[0% - 100%]
[PERIODONTICS]		
[Crown Lengthening] [Limited [1] per quadrant or site per [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]

[BENEFIT DESCRIPTION & LIMITATION]	**[NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].]	**[NON-NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].] [[2] The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[Gingivectomy/Gingivoplasty] [Limited [1] per quadrant or site per [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Gingival Flap Procedure] [Limited [1] per quadrant or site per [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Osseous Graft] [Limited [1] per quadrant or site per [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Osseous Surgery] [Limited [1] per quadrant or site per [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Guided Tissue Regeneration] [Limited [1] per quadrant or site per [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Soft Tissue Surgery] [Limited [1] per quadrant or site per [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Periodontal Maintenance] [Is Covered in combination with [dental prophylaxis] but not on same date of service, benefit is not to exceed in combination with [dental prophylaxis] [2] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Full Mouth Debridement] [Limited to once per [consecutive] [60 months]	[0% - 100%]	[0% - 100%]

[BENEFIT DESCRIPTION & LIMITATION]	**[NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].]	**[NON-NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].] [[2] The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[calendar year] [Plan Year].]		
[Provisional Splinting] [Cannot be used to restore vertical dimension or as part of full mouth rehabilitation, should not include use of laboratory based crowns and/or fixed partial dentures (bridges).] [Covered for single tooth extractions.] [Exclusion of laboratory based crowns or bridges for the purposes of provisional splinting.]	[0% - 100%]	[0% - 100%]
[Scaling and Root Planing] [Limited to [1] [time] per quadrant per [consecutive] [24 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Localized Delivery of Antimicrobial Agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report] [Limited to [1] per quadrant per site for refractory pockets by report.]	[0% - 100%]	[0% - 100%]
[ORAL SURGERY]		
[Alveoloplasty] [Not Covered for single tooth extractions; bone recontouring should be included in the extraction fee.]	[0% - 100%]	[0% - 100%]
[Biopsy] [Limited to [1] biopsy per site per visit.] [Not Covered if done in conjunction with another biopsy procedure.]	[0% - 100%]	[0% - 100%]

[BENEFIT DESCRIPTION & LIMITATION]	**[NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].]	**[NON-NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].] [[2] The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[Frenectomy/Frenulopasty] [Limited to [1] per site per [consecutive] [60 months] [calendar year] [Plan Year].] [Frenectomy and frenuloplasty cannot be billed on same date of service.]	[0% - 100%]	[0% - 100%]
[Surgical Incision] [Limited to [1] per site per visit.]	[0% - 100%]	[0% - 100%]
[Removal of a Benign Cyst/Lesions] [Limited to [1] per site per visit.]	[0% - 100%]	[0% - 100%]
[Removal of Torus] [Limited to [1] per site per visit.]	[0% - 100%]	[0% - 100%]
[Root Removal, Surgical] [Limited to [1] [time] per tooth per lifetime.]	[0% - 100%]	[0% - 100%]
[Simple Extractions] [Limited to [1] [time] per tooth per lifetime.]	[0% - 100%]	[0% - 100%]
[Surgical Extraction of Erupted Teeth or Roots] [Limited to [1] [time] per tooth per lifetime.]	[0% - 100%]	[0% - 100%]
[Surgical Extraction of Impacted Teeth] [Limited to [1] [time] per tooth per lifetime.]	[0% - 100%]	[0% - 100%]
[Surgical Access, Surgical Exposure, or Immobilization of Unerupted Teeth] [Limited to [1] per site per lifetime.]	[0% - 100%]	[0% - 100%]

[BENEFIT DESCRIPTION & LIMITATION]	**[NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].]	**[NON-NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].] [[2] The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[Primary Closure of a Sinus Perforation] [Limited to [1] per tooth per lifetime.]	[0% - 100%]	[0% - 100%]
[Placement of Device to Facilitate Eruption of Impacted Tooth] [Limited to [1] [time] per tooth per lifetime.]	[0% - 100%]	[0% - 100%]
[Transseptal Fiberotomy/Supra Crestal Fiberotomy, by report] [Limited to [1] [time] per tooth per lifetime.]	[0% - 100%]	[0% - 100%]
[Vestibuloplasty] [Limited to [1] [time] per site per [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Bone Replacement Graft for Ridge Preservation - per site] [Limited to [1] per site per lifetime.] [Not Covered if done in conjunction with other bone graft replacement procedures.]	[0% - 100%]	[0% - 100%]
[Excison of Hyperplastic Tissue or Pericoronal Gingiva] [Limited to [1] per site per [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Appliance Removal (not by dentist who placed appliance) includes removal of arch bar] [Limited to once per appliance per lifetime.]	[0% - 100%]	[0% - 100%]
[Tooth Reimplantation and/or Transplantation Services] [Limited to [1] per site per	[0% - 100%]	[0% - 100%]

[BENEFIT DESCRIPTION & LIMITATION]	**[NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].]	**[NON-NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].] [[2] The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
lifetime.]		
[Oroantral Fistula Closure] [Limited to [1] per site per visit.]	[0% - 100%]	[0% - 100%]
[ADJUNCTIVE SERVICES]		
[Analgesia] [Covered when Necessary in conjunction with Covered Dental Services.] [If required for patients under [6] years of age or patients with behavioral problems or physical disabilities or if it is [medically] [clinically] Necessary.] [Covered for patients over age of [6] if it is [medically] [clinically] Necessary.]	[0% - 100%]	[0% - 100%]
[Desensitizing Medicament] [Limited to [1] [time] per tooth per [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[General Anesthesia] [Covered when Necessary in conjunction with Covered Dental Services.] [If required for patients under [6] years of age or patients with behavioral problems or physical disabilities or if it is [medically] [clinically] Necessary.] [Covered for patients over age of [6] if it is [medically] [clinically] Necessary.]	[0% - 100%]	[0% - 100%]
[Local Anesthesia] [Not Covered in conjunction with operative or surgical procedure.] [Limited to [1] [charge] per visit. [Limited to [1] [charge] per [consecutive] [60 months]	[0% - 100%]	[0% - 100%]

[BENEFIT DESCRIPTION & LIMITATION]	**[NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].]	**[NON-NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].] [[2] The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[calendar year] [Plan Year].		
[Intravenous Sedation and Analgesia] [Covered when Necessary in conjunction with Covered Dental Services.] [If required for patients under [6] years of age or patients with behavioral problems or physical disabilities or if it is [medically] [clinically] Necessary.] [Covered for patients over age of [6] if it is [medically] [clinically] Necessary.]	[0% - 100%]	[0% - 100%]
[Therapeutic Drug Injection, by report/Other Drugs and/or Medicaments, by report] [Limited to [1] per visit per [consecutive] [12 months] [calendar year] [Plan Year.]	[0% - 100%]	[0% - 100%]
[Occlusal Adjustment] [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Occlusal Guards] [Limited to [1] guard every [consecutive] [60 months] [calendar year] [Plan Year] and only if prescribed to control habitual grinding.]	[0% - 100%]	[0% - 100%]
[Occlusal Guard Reline and Repair] [Limited to relining and repair performed more than [6] months after the initial insertion.] [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]

[BENEFIT DESCRIPTION & LIMITATION]	**[NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].]	**[NON-NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].] [[2] The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[Occlusion Analysis - Mounted Case] [Limited to [1] [time] per [consecutive] [60 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Palliative Treatment] [Covered as a separate benefit only if no other services, other than the exam and radiographs, were done on the same tooth during the visit.]	[0% - 100%]	[0% - 100%]
[Consultation (diagnostic service provided by dentists or physician other than practitioner providing treatment.)] [Not Covered if done with exams or professional visit.]	[0% - 100%]	[0% - 100%]
[MAJOR RESTORATIVE SERVICES] [Replacement of [complete] [dentures], [fixed] [or] [removable] [partia] [dentures], [crowns], [inlays] [or] [onlays] previously submitted for payment under the plan is limited to [1] [time] per [consecutive] [120 months] [calendar year] [Plan Year] from initial or supplemental placement.]		
[Coping] [Limited to [1] per tooth per [consecutive] [120 months] [calendar year] [Plan Year].] [Not Covered if done at the same time as a crown on same tooth.]	[0% - 100%]	[0% - 100%]
[Crowns – Retainers/Abutments] [Limited to [1] [time] per tooth per [consecutive] [120 months] [calendar year] [Plan Year].] [Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.]	[0% - 100%]	[0% - 100%]
[Crowns - Restorations]	[0% - 100%]	[0% - 100%]

[BENEFIT DESCRIPTION & LIMITATION]	**[NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].]	**[NON-NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].] [[2] The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[Limited to [1] [time] per tooth per [consecutive] [120 months] [calendar year] [Plan Year].] [Covered only when a filling cannot restore the tooth.] [Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.]		
[Temporary Crowns - Restorations] [Limited to [1] [time] per tooth per [consecutive] [120 months] [calendar year] [Plan Year].] [Covered only when a filling cannot restore the tooth.] [Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.]	[0% - 100%]	[0% - 100%]
[Inlays/Onlays – Retainers/Abutments] [Limited to [1] [time] per tooth per [consecutive] [120 months] [calendar year] [Plan Year].] [Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.]	[0% - 100%]	[0% - 100%]
[Inlays/Onlays - Restorations] [Limited to [1] [time] per tooth per [consecutive] [120 months] [calendar year] [Plan Year].] [Covered only when a filling cannot restore the tooth.] [Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.]	[0% - 100%]	[0% - 100%]

[BENEFIT DESCRIPTION & LIMITATION]	**[NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].]	**[NON-NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].] [[2] The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[Pontics] [Limited to [1] [time] per tooth per [consecutive] [120 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Retainer-Cast Metal for Resin Bonded Fixed Prosthesis] [Limited to [1] [time] per [consecutive] [120 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Pin Retention] [Limited to [2] [pins] per tooth; not Covered in addition to cast restoration.]	[0% - 100%]	[0% - 100%]
[Post and Cores] [Covered only for teeth that have had root canal therapy.]	[0% - 100%]	[0% - 100%]
[Re-Cement Inlays/Onlays, Crowns, Bridges and Post and Core] [Limited to [1] per [consecutive] [12 months] [calendar year] [Plan Year].] [Limited to those performed more than [12 months] after the initial insertion.]	[0% - 100%]	[0% - 100%]
[Sedative Filling] [Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.]	[0% - 100%]	[0% - 100%]
[Stainless Steel Crowns] [Limited to [1] [time] per tooth per [consecutive] [120 months] [calendar year] [Plan Year].] [Covered only when a filling cannot restore the tooth.]	[0% - 100%]	[0% - 100%]

[BENEFIT DESCRIPTION & LIMITATION]	**[NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].]	**[NON-NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].] [[2] The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.]		
[FIXED PROSTHETICS] [Replacement of [complete dentures], [fixed or removable partial dentures,] [crowns,] [inlays] [or] [onlays] previously submitted for payment under the plan is limited to [1] [time] per [consecutive] [120 months] [calendar year] [Plan Year] from initial or supplemental placement.]		
[Fixed Partial Dentures (Bridges)] [Limited to [1] [time] per tooth per [consecutive] [120 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[REMOVABLE PROSTHETICS] [Replacement of [complete dentures], [fixed or removable partial dentures,] [crowns,] [inlays] [or] [onlays] previously submitted for payment under the plan is limited to [1] [time] per [consecutive] [120 months] [calendar year] [Plan Year] from initial or supplemental placement.]		
[Full Dentures] [Limited to [1] per [consecutive] [120 months] [calendar year] [Plan Year].] [No additional allowances for precision or semi-precision attachments.]	[0% - 100%]	[0% - 100%]
[Partial Dentures] [Limited to [1] per [consecutive] [120 months] [calendar year] [Plan Year].] [No additional allowances for precision or semi precision attachments.]	[0% - 100%]	[0% - 100%]
[Relining and Rebasing Dentures] [Limited to relining/rebasing performed more than [12 months] after the initial insertion.] [Limited to [1] [time] per [consecutive] [36 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]

[BENEFIT DESCRIPTION & LIMITATION]	**[NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].]	**[NON-NETWORK] [COPAYMENT** is shown as a percentage of Eligible Expenses [[1]after applicable Deductible is satisfied].] [[2] The Covered Person must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.]
[Tissue Conditioning - Maxillary or Mandibular] [Limited to [1] [time] per [consecutive] [12 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]
[Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns] [Limited to repairs or adjustments performed more than [12 months] after the initial insertion.] [Limited to [1] per [consecutive] [24 months] [calendar year] [Plan Year].]	[0% - 100%]	[0% - 100%]

Vision Care Insurance Policy

United HealthCare Insurance Company

[450 Columbus Boulevard

Hartford, Connecticut 06115-0450

[1-800-638-3120]]

A Limited Benefit Policy

Issued To:	[Any School] ("Policyholder")
Policy Number:	[00000]
Policy Effective Date:	[January 1, 2008]
Policy Termination Date:	[December 31, 2008]

United HealthCare Insurance Company agrees to pay the benefits and provide the other rights set forth in the Policy, in consideration of the Policyholder's application and payment of Policy Charges.

Upon receipt of the Policyholder's application and payment of the required Policy Charges, this Policy is deemed executed.

As used in this Policy, the words "we", "us", "our", and "the Company" refer to United HealthCare Insurance Company.

The Policy will take effect as of the Policy Effective Date set forth above, provided that it has been signed by an officer of the Company, and the Policyholder has signed the application.

This Policy replaces and supersedes any previous agreements relating to the coverage of vision services between the Policyholder and the Company. The terms and conditions of this Policy will in turn be superseded by those of any subsequent agreements relating to the coverage of vision services between the Policyholder and the Company.

This Policy will become effective at 12:01 a.m. at the Policyholder's address on the Policy Effective Date, and will be continued in force by the timely payment of the required Policy Charges when due, subject to termination of this Policy as provided herein. When the Policy is terminated as provided for in the *Termination of the Entire Policy* section, this Policy and all coverage under this Policy will end at 12:00 midnight on the date of termination.

NON-RENEWABLE ONE YEAR TERM INSURANCE-THIS POLICY WILL NOT BE RENEWED.

This Policy is delivered in and governed by the laws of the [State of _____].

Issued By:

United HealthCare Insurance Company

[Signature of authorized company officer]

[Title of authorized company officer]

Vision Care Insurance Policy Table of Contents

Definitions

{Copayment – The charge, in addition to the Premium, that the Covered Person is required to pay to a Network Provider for certain Services payable under the Policy. The Covered Person is responsible for the payment of any Copayment directly to the provider of the Service at the time of service, or when billed by the provider.}

Covered Person –The Subscriber {or an Enrolled Dependent}, but this term applies only while the person is enrolled under the Policy.

{Covered Contact Lens Selection – A selection of available contact lenses that may be obtained from a Network Provider on a covered-in-full basis, subject to payment of any applicable Copayment.}

{Covered Eyeglass Frames Selection – A selection of available eyeglass frames that may be obtained from a Network Provider on a covered-in-full basis, subject to payment of any applicable Copayment.}

{Deductible – The amount a Covered Person must pay for Services in a [Plan Year] [calendar year] before the Company will begin paying for {Network{ or Non-Network}} Benefits {in that [Plan Year] [calendar year]}}.

{Dependent –

1. The Subscriber's legal spouse. {All references to the spouse of a Subscriber shall include Domestic Partner}.; or
2. An unmarried dependent child of the Subscriber or the Subscriber's spouse (including a natural child, stepchild, a legally adopted child, a child placed for adoption, or a child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse). [The term "child" also includes a grandchild of either the Subscriber or the Subscriber's spouse.] To be eligible for coverage under the Policy, a Dependent must principally reside within the United States. The definition of "Dependent" is subject to the following conditions and limitations:

    A. The term "Dependent" will not include any unmarried dependent child [19] years of age or older, except as stated in {the next paragraph, or as stated in} *Section 3: Termination Provisions* section titled *"Extended Coverage for Dependent Handicapped Children"*.

    [B. The term "Dependent" will include an unmarried dependent child who is [19] years of age or older, but less than [23] years of age [as defined under Full-time Student], if evidence satisfactory to the Company of the following conditions is furnished upon request:

        1. The child is not regularly employed on a full-time basis; and
        2. The child is a Full-time student; and
        3. The child is primarily dependent upon the Subscriber for support and maintenance.]

The Subscriber agrees to reimburse the Company for any Services provided to the child at a time when the child did not satisfy these conditions.

[The term "Dependent" also includes a child for whom coverage for Services is required through a 'Qualified Medical Child Support Order' or other court or administrative order. The Policyholder is responsible for determining if an order meets the criteria of a 'Qualified Medical Child Support Order'.]

{The term "Dependent" does not include anyone who is also enrolled as a Subscriber, nor can anyone be a "Dependent" of more than one Subscriber.}]}

{Domestic Partner – A person of the [opposite sex] [same sex] [opposite or same sex] with whom the Subscriber has established a Domestic Partnership. In no event will a person's legal spouse be considered a Domestic Partner.}

{Domestic Partnership – A relationship between the Subscriber and one other person of the [opposite sex] [same sex] [opposite or same sex]. The following requirements apply to both persons:

- [They share the same permanent residence and the common necessities of life;
- They are not related by blood or a degree of closeness which would prohibit marriage in the law of state in which they reside;
- Each is at least 18 years of age;
- Each is mentally competent to consent to contract;
- Neither is currently married to another person under either a statutory or common law;
- They are financially interdependent and have furnished at least two of the following documents evidencing such financial interdependence:
    - Have a single dedicated relationship of at least 6 months duration.
    - Joint ownership of residence.
    - At least two of the following:
        - Joint ownership of an automobile.
        - Joint checking, bank or investment account.
        - Joint credit account.
        - Lease for a residence identifying both partners as tenants.
        - A will and/or life insurance policies which designates the other as primary beneficiary.
- The Subscriber and Domestic Partner must jointly sign an affidavit of Domestic Partnership.]}

Eligible Person – A student registered at the institution of the Policyholder who meets the eligibility requirements specified in the Policyholder's application.

{Enrolled Dependent – A Dependent who is properly enrolled for Coverage under the Policy.}

{Experimental, Investigational or Unproven Services – Medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Company makes a determination regarding coverage in a particular case, is determined to be:

A. Not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or

B. Subject to review and approval by any institutional review board for the proposed use; or

C. The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or

D. Not demonstrated through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.}

{Foreign Services –Services provided outside the U.S. and U.S. Territories.}

[Full-time Student - a person who is enrolled in and attending, full-time, a recognized course of study or training at:

A. An accredited high school;

B. An accredited college or university; or

C. A licensed vocational school, technical school, beautician school, automotive school or similar training school.

Full-time Student status is determined in accordance with the standards set forth by the educational institution. A person ceases to be a Full-time Student [[1]at the end of the calendar [[2]month][[2]year] during

which][1on the date] the person graduates or otherwise ceases to be enrolled and in attendance at the institution on a full-time basis.

A person continues to be a Full-time Student during periods of regular vacation established by the institution. If the person does not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end on [3the last day of the calendar [4month][4year]][2the date] in which the person was enrolled and in attendance at the institution on a full-time basis.]

Grace Period – A period of time following the Payment Due Date during which the Policyholder may pay the due Policy Charge without penalty under the Policy.

{Maximum Annual Benefit – The maximum amount paid for covered Services during a [Plan Year] [calendar year] for a Covered Person under the Policy.}

{Maximum Policy Benefit – The maximum amount paid for covered Services during the entire period of time that the Covered Person is Covered under any Policy issued by the Company to the Policyholder.}

{Network Benefits – Coverage for Services provided by a Network Provider.}

{Non-Network Benefits – Coverage for Services provided by a provider other than a Network Provider.}

{Network Provider – Any optometrist, ophthalmologist, optician or other person who may lawfully provide Services who has contracted, directly or indirectly, with us, to provide Services to Covered Persons participating in our vision plans.}

Payment Due Date – The date on which the Policyholder's payment of a Policy Charge is due.

{**Plan Year -** The period of time, usually beginning with the Policy's effective date of any year and terminating on the Termination Date of the succeeding year, when accumulators for Deductibles and plan maximums are calculated.}

Policy – The Group Vision Care Insurance Policy issued to the Policyholder.

Policy Charge – The sum of the Premiums for all Covered Persons.

Policy Effective Date – The date on which the Policyholder's coverage under the plan becomes effective.

Policyholder - the educational institution or other defined or otherwise legally constituted group to whom the Policy is issued.

Premium – The periodic fee required to maintain coverage of Covered Persons in accordance with the terms of the Policy.

Service – Any covered benefit listed in *Benefit Descriptions*.

Subscriber – An Eligible Person who is properly enrolled for Coverage under the Policy and is the person on whose behalf the Policy is issued to the Policyholder.

Eligibility and Effective Date of Coverage

Eligibility

Each person who belongs to one of the Classes of Persons to be Insured as set forth in the application is eligible to be insured under the Policy. {[The Eligible Person must actively attend classes for at least the first [31] days after the date for which coverage is purchased. [Home study,] [correspondence,] [Internet,] [and] [television (TV)] courses do not fulfill the eligibility requirements that the Eligible Person actively attend classes.]} The Company maintains its right to investigate [eligibility or] student status and attendance records to verify that the Policy eligibility requirements have been met. If and when the Company discovers that the Policy eligibility requirements have not been met, its only obligation is refund of premium.

Effective Date of Coverage

In no event is there coverage for Services rendered or delivered before the effective date of coverage.

Enrollment

Eligible Persons may enroll themselves {and their Dependents} for coverage under the Policy during any enrollment period by submitting a form provided or approved by the Company. In addition, new Eligible Persons {and new Dependents} may be enrolled as described below. {Dependents of an Eligible Person may not be enrolled unless the Eligible Person is also enrolled for coverage under the Policy.}

{If both spouses are Eligible Persons of the Policyholder, each may enroll as a Subscriber or be covered as an eligible Dependent of the other, but not both. If both parents of an eligible Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.}

Coverage for a Newly Eligible Person

Coverage for a Subscriber {and any of their Dependents} will take effect on the date agreed to by the Policyholder and the Company. Coverage is effective only if the Company receives any required Premium and a properly completed enrollment form within [31 days] of the date the Subscriber first becomes eligible.

{Coverage for a Newly Eligible Dependent

You may make coverage changes during the year for any Dependent whose status as a Dependent is affected by a marriage, divorce, legal separation, annulment, birth, legal guardianship, placement for adoption or adoption, as required by federal law. In cases of marriage, you must submit the required contribution of coverage and a properly completed enrollment form within [31 days] of the marriage. Otherwise, you will need to wait until the next enrollment period.

Coverage for a new Dependent acquired by court or administrative order, or marriage shall take effect on [the date of the event]. Coverage is effective only if the Company receives any required Premium and is notified of the event within [31 days].

All vision insurance benefits applicable for children, including the Necessary care or treatment of medically diagnosed congenital defects or birth abnormalities, will apply with respect to Your newborn child from the moment of birth. You must submit the required contribution of coverage and a properly completed enrollment form within 90 days of birth.

All vision insurance benefits applicable for children, including the Necessary care or treatment of medically diagnosed congenital defects or birth abnormalities, will apply with respect to adopted children from the moment of placement for adoption if petition for adoption and application for coverage are filed within 60 days of placement or from the moment of birth if petition for adoption and application for coverage are filed within 60 days of birth. }

Termination

Termination of the Entire Policy

This Policy and all Coverage under this Policy will automatically terminate on the earliest of the dates specified below:

[1]*Select the applicable termination date option.*

1. At the Company's option, {[1]on the date} {[1]on the last day of the calendar month} {[1]retroactive to the last paid date of Coverage}, if the Grace Period expires and any Policy Charge remains unpaid.

2. On the date specified by the Company in written notice to the Policyholder that this Policy will be terminated because the Policyholder provided the Company with false information material to the execution of this Policy or to the provision of Coverage under this Policy. The Company has the right to rescind this Policy back to the effective date.

Payment and Reimbursement Upon Termination

Upon any termination of this Policy, the Policyholder will be and will remain liable to the Company for the payment of any and all Premiums which are unpaid at the time of termination, including a pro rata fee for any period this Policy was in force during the Grace Period, if any, preceding the termination.

Termination of Covered Person's Coverage

A Covered Person's coverage, including coverage for Services rendered after the date of termination for conditions arising prior to the date of termination, will automatically terminate on the earliest of the dates specified below:

1. The date requested in such notice when the Company receives written notice from the Policyholder instructing the Company to terminate coverage of the Subscriber or any Covered Person.

When any of the following apply, the Company will provide written notice of termination to the Subscriber:

2. The date specified by the Company that all coverage will terminate due to fraud or misrepresentation or because the Subscriber knowingly provided the Company with false material information. Such information may include, but is not limited to, information relating to residence, information relating to another person's eligibility for coverage or status as a Dependent. The Company has the right to rescind coverage back to the Policy Effective Date.
3. The date specified by the Company that coverage will terminate due to material violation of the terms of the Policy.
4. The date specified by the Company that the Covered Person's coverage will terminate because the Covered Person has committed acts of physical or verbal abuse that pose a threat to the Company's staff, a provider, or other Covered Persons.

{5. The date specified by the Company that all Coverage will terminate because the Covered Person permitted the use of his or her ID card by any unauthorized person or used another person's card.}

{6. The date specified by the Company that the Covered Person's coverage will terminate because the Subscriber failed to pay a required [Premium].}

If covered Services are in progress on the date which coverage terminates, such Services will be completed, except where termination is due to fraud, misrepresentation, material violation of the terms of the Policy, failure to pay required Premiums, or acts of physical or verbal abuse.

Reimbursement for Services

The Covered Person will be responsible for any claims paid by the Company when coverage was provided in error, except where that error was made by the Company.

{Extended Coverage for Handicapped Dependent Children

Coverage of an unmarried Enrolled Dependent who is incapable of self-support because of mental retardation or physical handicap will be continued beyond the limiting age provided that:

A. The Enrolled Dependent becomes so incapacitated prior to attainment of the limiting age;

B. The Enrolled Dependent is chiefly dependent upon the Subscriber for support and maintenance;

C. Proof of such incapacity and dependence is furnished to the Company; and

D. Payment of any required contribution for the Enrolled Dependent is continued.

Coverage will continue so long as the Enrolled Dependent continues to be so incapacitated and dependent, unless otherwise terminated in accordance with the terms of the Policy. Before granting this extension, the Company may reasonably require that the Enrolled Dependent be examined at the Company's expense by a physician designated by the Company. At reasonable intervals, the Company may require satisfactory proof of the Enrolled Dependent's continued incapacity and dependency, including medical examinations at the Company's expense. Such proof will not be required more often than once a year. Failure to provide such satisfactory proof will result in the termination of the Enrolled Dependent's coverage under the Policy.}

Benefit Descriptions

{Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which the Covered Person resides, to include:

[1. A case history, including chief complaint and/or reason for examination, patient medical/eye history, current medications, etc.;
2. Recording of monocular and binocular visual acuity, far and near, with and without present correction (20/20, 20/40, etc.);
3. Cover test at 20 feet and 16 inches (checks eye alignment);
4. Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception;
5. Pupil responses (neurological integrity);
6. External exam;
7. Internal exam;
8. Retinoscopy (when applicable) – objective refraction to determine lens power of corrective Subjective refraction – to determine lens power of corrective lenses;
9. Phorometry/Binocular testing – far and near: how well eyes work as a team;
10. Tests of accommodation and/or near point refraction: how well Covered Person sees at near point (reading, etc.);
11. Tonometry, when indicated: test pressure in eye (glaucoma check);
12. Ophthalmoscopic examination of the internal eye;
13. Confrontation visual fields;
14. Biomicroscopy;
15. Color vision testing;
16. Diagnosis/prognosis; and
17. Specific recommendations.]

Post examination procedures will be performed only when materials are required.}

{Eyeglass Lenses

Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.}

{Eyeglass Frames

A structure that contains eyeglasses lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.}

{Optional Lens Extras

Special lens stock or modifications to lenses that do not correct visual acuity problems. Optional Lens Extras include options such as, but not limited to, tinted lenses, polycarbonate lenses, transition lenses, high-index lenses, progressive lenses, ultraviolet coating, scratch-resistant coating, edge coating, and photochromatic coating.}

{Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.}

{Necessary Contact Lenses

This benefit is available where a provider has determined a need for and has prescribed the service. Such determination will be made by the provider and not by us.

Contact lenses are necessary if [the Covered Person has:

1. Keratoconus or irregular astigmatism;
2. Anisometropia of 3.50 diopters or more;
3. Post-cataract surgery without intraocular lens; or
4. Visual acuity in the better eye of less than 20/70 with visual correction by eyeglasses but better than 20/70 with visual correction by contact lenses.]}

{Foreign Services

{Foreign Services will be treated as Non-Network Benefits under this Policy.} Payments will be made in [U.S. currency] and dispersed to the [U.S. address] of the [Subscriber]. {The Company makes no guarantee on value of payment and will not protect against currency risk.} {Currency valuations for payment liability will be based on [exchange rates published in the Wall Street Journal on the date the claim is processed].}}

{Obtaining Services

To find a Network Provider, the Covered Person may call [the Spectera Locator Service at 1-800-839-3242]. The Covered Person may also access a listing of Network Providers on the Internet at [www.spectera.com].

{A Covered Person also may obtain Services from a non Network Provider. However, the amount of Coverage may be reduced.}}

Claims

Notice of Claim

Notice of claim as determined by us must be given to us within [365 days] of the date such loss begins. The notice must be given with sufficient information to identify the Covered Person. Failure to file such notice within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, the notice must be given as soon as reasonably possible.

Payment of Claims

{When obtaining [Services] from a Network Provider, the Covered Person will be required to pay {a Copayment and} any charges not covered by the Policy to their Provider. When obtaining Services from a Network Provider, the Covered Peron will not be required to submit a claim form.}

{When obtaining [Services]{ from a non-Network Provider}, the Covered Person will be required to pay all billed charges to their provider. The Covered Person may then obtain reimbursement from us for the covered portion of Services.}

{Reimbursement

To file a claim for reimbursement for Services{ rendered by a non-Network Provider, or for Services covered as reimbursements (whether or not rendered by a Network Provider or a non-Network Provider)}, provide the following information [on claim form acceptable to the Company]:

[1. Itemized receipts;

2. Subscriber name;

3. Subscriber's identification number;

4. Patient name; and

5. Patient date of birth.]

Submit the above information to us:

By mail:

[Spectera Claims Department

P.O. Box 30978

Salt Lake City, UT 84130]

By facsimile (fax):

[248-733-6060]

Reimbursements are payable in accordance with any state prompt pay requirements after the Company receives acceptable proof of loss.}

Examination of Covered Persons

In the event of a question or dispute concerning Coverage for vision Services, the Company may reasonably require that a Covered Person be examined at the Company's expense by a [Network Provider] acceptable to the Company.

Complaint Procedures

Complaint Resolution

If a Covered Person has a concern or question regarding the provision of Services or benefits under the Policy, they should contact the Company's customer service department. Customer service representatives are available to take calls [during regular business hours, Monday through Friday. At other times, the Covered Person may leave a message on voicemail]. A customer service representative will return the Covered Person's call. If the Covered Person would rather send their concern to us in writing at this point, the Company's authorized representative can provide them with the appropriate address.

If the customer service representative cannot resolve the issue to the Covered Person's satisfaction over the phone, he or she can provide the Covered Person with the appropriate address to submit a written complaint. We will notify the Covered Person of our decision regarding their complaint within [30 days] of receiving it.

If the Covered Person disagrees with our decision after having submitted a written complaint, they can ask us in writing to formally reconsider their complaint. If the complaint relates to a claim for payment, the request should include:

[The patient's name and identification number.

The date(s) of service(s).

The provider's name.

The reason the Covered Person believes the claim should be paid.

Any new information to support the Covered Person's request for claim payment.]

We will notify the Covered Person of our decision regarding our reconsideration of their complaint within [60 days] of receiving it. {If the Covered Person is not satisfied with our decision, they have the right to take their complaint to [the Office of the Commissioner of Insurance].}

Complaint Hearing

[If the Covered Person requests a hearing,] [w]e will appoint a committee to resolve or recommend the resolution of the Covered Person's complaint. If the Covered Person's complaint is related to clinical matters, the Company may consult with, or seek the participation of, medical and/or vision experts as part of the complaint resolution process.

The committee will advise the Covered Person of the date and place of their complaint hearing. The hearing will be held within [60 days] following the receipt of the Covered Person's request by the Company, at which time the committee will review testimony, explanation or other information that it decides is necessary for a fair review of the complaint.

We will send the Covered Person written notification of the committee's decision within [30 days] of the conclusion of the hearing. If the Covered Person is not satisfied with our decision, they have the right to take their complaint to [the Office of the Commissioner of Insurance].

{Subrogation

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. The Company will be subrogated to and will succeed to all rights of recovery, under any legal theory of any type, for the reasonable value of services and benefits provided by the Company to a Covered Person from: (i.) third parties, including any person alleged to have caused the Covered Person to suffer injuries or damages; (ii.) the Covered Person's employer; or (iii.) any person or entity obligated to provide benefits or payments to the Covered Person, including benefits or payments for underinsured or uninsured motorist protection (these third parties and persons or entities are collectively referred to as "Third Parties"). The Covered Person must agree to assign to the Company all rights of recovery against Third Parties, to the extent of the reasonable value of services and benefits provided by the Company, plus reasonable costs of collection.

The Covered Person must cooperate with the Company in protecting the Company's legal rights to subrogation and reimbursement, and acknowledge that the Company's rights will be considered as the first priority claim against Third Parties, to be paid before any other claims by the Covered Person are paid. The Covered Person will do nothing to prejudice the Company's rights under this provision, either before or after the need for services or benefits under the Policy. The Company may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in the Covered Person's name. For the reasonable value of services provided under the Policy, the Company may collect, at its option, amounts from the proceeds of any settlement (whether before or after any determination of liability) or judgment that may be recovered by the Covered Person or their legal representative, regardless of whether or not the Covered Person has been fully compensated. The Covered Person will hold in trust any proceeds of settlement or judgment for the benefit of the Company under these subrogation provisions and the Company will be entitled to recover reasonable attorney fees from the Covered Person incurred in collecting proceeds held by the Covered Person. The Covered Person will not accept any settlement that does not fully compensate or reimburse the Company without the written approval of the Company. The Covered Person must agree to execute and deliver such documents (including a written confirmation of assignment, and consents to release dental records), and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as may be reasonably requested by the Company.]

{Refund of Expenses

{Refund of Overpayments

If the Company pays benefits for expenses incurred on account of a Covered Person, that Covered Person or any other person or organization that was paid must make a refund to the Company if:

A. All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;

B. All or some of the payment made by the Company exceeded the benefits under the Policy; or

C. All or some of the payment was made in error.

The refund equals the amount the Company paid in excess of the amount it should have paid under the Policy.

If the refund is due from another person or organization, the Covered Person agrees to help the Company get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Company may reduce the amount of any future benefits that are payable under the Policy. The Company may also reduce future benefits under any other group benefits plan administered by the Company for the Policyholder. The reductions will equal the amount of the required refund. The Company may have other rights in addition to the right to reduce future benefits.}

{Refund of Benefits Paid by Third-Parties

If the Company pays benefits for expenses incurred on account of a Covered Person, the Subscriber or any other person or organization that was paid must make a refund to the Company if all or some of the expenses were recovered from or paid by a source other than the Policy as a result of claims against a third party for negligence, wrongful acts or omissions. The refund equals the amount of the recovery or payment, up to the amount the Company paid.

If the refund is due from another person or organization, the Covered Person agrees to help the Company get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Company may reduce the amount of any future benefits that are payable under the Policy. The Company may also reduce future benefits under any other group benefits plan administered by the Company for the Policyholder. The reduction will equal the amount of the required refund. The Company may have other rights in addition to the right to reduce future benefits.}}

Exclusions

The following Services and materials are excluded from coverage under the Policy:

[1. {Non-prescription items (e.g. Plano lenses).}

2. {Services that the Covered Person, without cost, obtains from any governmental organization or program.}

3. {Services for which the Covered Person may be compensated under Worker's Compensation Law, or other similar employer liability law.}

4. {Any eye examination required by an employer as a condition of employment, by virtue of a labor agreement, a government body, or agency.}

5. {Medical or surgical treatment for eye disease, which requires the services of a physician.}

6. {Expenses incurred prior to meeting the Deductible.}

7. {Expenses incurred in excess of the Maximum Annual Benefit.}

8. {Expenses incurred in excess of the Maximum Policy Benefit.}

9. {Replacement or repair of lenses and/or frames that have been lost or broken.}

10. {Optional Lens Extras not listed in the *Table of Benefits*.}

11. {Missed appointment charges.}

12. {Applicable sales tax charged on Services.}

13. {Services that are not specifically covered by the Policy.}

14. {Procedures that are considered to be Experimental, Investigational or Unproven. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.}]

General Provisions

Legal Actions

No action at law or in equity may be brought to recover on the Policy prior to the expiration of 60 days after proof of loss has been filed. No such action may be brought more than 3 years after the claim is required to be filed.

Time Limit on Certain Defenses

No statement made by the Policyholder, except a fraudulent statement, will be used to void this Policy after it has been in force for a period of 2 years.

Entire Contract

This Policy, the Policyholder's Application, the *Table(s) of Benefits* and any amendments, riders and endorsements will constitute the entire contract. Any amendments, riders, endorsements, *or Table(s) of Benefits* issued after the Policy Effective Date will be made a part of the Policy.

Amendments and Alterations

Amendments to the Policy are effective upon [31 days] written notice to the Policyholder. Riders are effective on the date specified by the Company. No change will be made to the Policy unless it is made by an Amendment or a Rider that is signed by an officer of the Company. No agent has authority to change the Policy or to waive any of its provisions.

Jurisdiction

The Policy has been issued and delivered in the Governing Jurisdiction shown on the first page of the Policy. The laws of such jurisdiction will govern its execution, performance and enforcement. Any provision of the Policy that is in conflict with such laws will be deemed amended to meet the minimum requirements of such laws.

Waiver/Estoppel

Nothing in the Policy or *Table of Benefits* is considered to be waived by any party unless the party claiming the waiver receives the waiver in writing. A waiver of one provision does not constitute a waiver of any other. A failure of either party to enforce at any time any of the provisions of the Policy or *Table of Benefits* or to exercise any option which is herein provided, will in no way be construed to be a waiver of such provision of the Policy or *Table of Benefits*.

Relationship Between Parties

The relationships between the Company and providers, and the relationship between the Company and the Policyholder, are solely contractual relationships between independent contractors. Providers and the Policyholder are not agents or employees of the Company, nor is the Company or any employee of the Company an agent or employee of providers or of the Policyholder.

The relationship between a provider and any Covered Person is that of provider and patient. The provider is solely responsible for the services provided by it to any Covered Person. The Policyholder is solely responsible for enrollment and Coverage classification changes (including termination of a Covered Person's Coverage through the Company) and for the timely payment of the Policy Charge.

Workers' Compensation Not Affected

The Coverage provided under this Policy does not substitute for and does not affect any requirements for coverage by workers' compensation insurance.

Headings

The headings, titles and any table of contents contained in the Policy or *Table of Benefits* are for reference purposes only and will not in any way affect the meaning or interpretation of the Policy or *Table of Benefits*.

Unenforceable Provisions

If any provision of the Policy or *Table of Benefits* is held to be illegal or unenforceable by a court of competent jurisdiction, the remaining provisions will remain in effect and the illegal or unenforceable provision will be modified so as to conform to the original intent of the Policy or *Table of Benefits* to the greatest extent legally permissible.

Assignment of Benefits

No assignment of the benefits or of payment for reimbursement is binding unless agreed to in writing. Such agreement is not valid until approved by us.

Clerical Error

If a clerical error or other mistake occurs, that error will not deprive a Covered Person of Coverage under the Policy. A clerical error also does not create a right to benefits.

Notice

When the Company provides written notice regarding administration of the Policy to an authorized representative of the Policyholder, that notice is deemed notice to all affected Subscribers {and their Enrolled Dependents}. The Policyholder is responsible for giving notice to Covered Persons.

Administration

Notices

All notices or other communications required or permitted under this Policy will be in writing and will be delivered personally, by commercial overnight delivery service, or by registered or certified mail, return receipt requested, and will be deemed received: upon receipt (or the first business day after receipt, if received after business hours) in the case of personal delivery; three business days after the date of mailing in the case of certified or registered mail; and one business day after sending if delivered by overnight delivery service, addressed as follows:

If to the Company:

[Spectera, Inc.]

[2811 Lord Baltimore Drive]

[Baltimore, MD 21244]

[Attention: Account Management Services]

With a copy to the Legal Department

If to the Policyholder:

To the mailing address on file with the Company.

A party may change the address at which it elects to receive any notice provided under this Policy by advising the other party of such change in accordance with this section.

Records

The Policyholder will furnish the Company with all information and proofs that the Company may reasonably require with regard to any matters pertaining to this Policy. The Company may at any reasonable time inspect all documents furnished to the Policyholder by an individual in connection with the Coverage and any other records pertinent to the Coverage under this Policy.

During and after the termination of the Policy, the Company and its related entities may use and transfer the information gathered under the Policy for research and analytic purposes.

Administrative Services

The services necessary to administer this Policy and the Coverage provided under it will be provided in accordance with the Company's or its designee's standard administrative procedures. If the Policyholder requests that such administrative services be provided in a manner other than in accordance with these standard procedures, including requests for non-standard reports, the Policyholder will pay for such services or reports at the Company's or its designee's then-current charges for such services or reports.

Examination of Covered Persons

In the event of a question or dispute concerning Coverage for vision Services, the Company may reasonably require that a Covered Person be examined at the Company's expense by a [Network Provider] acceptable to the Company.

Information to be Provided by the Policyholder

The Policyholder will provide, with each Premium payment, a statement showing the number of persons enrolled for coverage during the time period. We will be permitted access to the Policyholder's records during reasonable business hours for the purpose of verifying such information.

Premium Rates and Policy Charge

Premium Rates

The Policyholder agrees to remit the premium for each Covered Person to the Company or its authorized agent within 20 days after the receipt of the premium. {The Premium rate in effect will be as indicated in Exhibit A.} The Company will have the right to examine all of the Policyholder's books and records relating to this policy at any time up to the later of 1)two years after the termination of the policy and 2)the date of final adjustment and settlement of all claims under this policy.

Payment of the Policy Charge

All premiums are payable in advance for each policy term in accordance with the Company's premium rates. The full premium must be paid even if the premium is received after the policy Effective Date. There is no pro-rata or reduced premium payment for late enrollees. There will be no refunds to students who cancel coverage under the policy, unless the Covered Person enters the armed forces.

Premium adjustments involving return of unearned premiums to the Policyholder will be limited to a period of 12 months immediately preceding the date of receipt by the Company of evidence that adjustments should be made. Premiums are payable to the Company, [P.O. Box 809026, Dallas, Texas 75380-9025.]

Grace Period

We will allow the Policyholder a Grace Period of [14 days] for any Premium due after the first Premium. During the Grace Period, the coverage will remain in effect provided the full premium is paid before the end of the Grace Period. Should a premium otherwise due, not be paid during the Grace Period, the Policy will terminate without further notice as of 12:00 midnight on the last day for which premiums were paid.

Clerical Errors

Clerical error will not deprive any individual of Coverage under this Policy or create a right to benefits. Failure to report the termination of Coverage will not continue such Coverage beyond the date it is scheduled to terminate according to the terms of this Policy. Upon discovery of a clerical error, any necessary appropriate adjustment in Premiums will be made. However, no such adjustment in Premiums or Coverage will be granted by the Company to the Policyholder for more than [60 days] of Coverage prior to the date the Company received notification of such clerical error.

Exhibit 1 to Vision Care Insurance Policy

Premiums

Monthly Premiums payable by or on behalf of Covered Persons are specified [[1]in the Cost Summary.] [[1]below:]

SERFF Tracking Number:	*UHLC-125885580*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*40786*
Company Tracking Number:	*VPOLCOC.SR.08.AR*		
TOI:	*H20G Group Health - Vision*	*Sub-TOI:*	*H20G.000 Health - Vision*
Product Name:	*Vision Group Blanket Forms*		
Project Name/Number:	*/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-125885580*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*40786*
Company Tracking Number:	*VPOLCOC.SR.08.AR*		
TOI:	*H20G Group Health - Vision*	*Sub-TOI:*	*H20G.000 Health - Vision*
Product Name:	*Vision Group Blanket Forms*		
Project Name/Number:	*/*		

Supporting Document Schedules

Satisfied -Name: Certification/Notice **Review Status:** Approved-Closed 11/06/2008

Comments:

Attachments:

readability.pdf

AR07I_NTC_GUARASSOC_AM_CS.doc

Satisfied -Name: Application **Review Status:** Approved-Closed 11/06/2008

Comments:

The application is for use with dental and vision and is being filed with the Dental forms. It was submitted as part of SERFF filing number UHLC-125884962 on November 3, 2008.

Satisfied -Name: Cover Letter **Review Status:** Approved-Closed 11/06/2008

Comments:

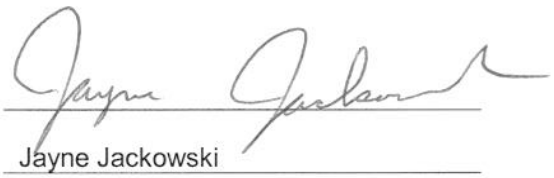
Attachment:

arletter.pdf

CERTIFICATION OF COMPLIANCE
FOR
READABILITY

Form Number(s)	Flesch Readability Score
VPOLCOC.SR.08.AR	50.3
VTOB.06	50.3

I hereby certify on behalf of **United HealthCare Insurance Company** that the above Flesch Scale Analysis Readability Score is accurate, based on the computer program used to calculate the scores, and comply with the readability requirements in your state.

Signature 

Print Name Jayne Jackowski

Title Compliance Analyst

Date November 3, 2008

SERFF Tracking Number:	*UHLC-125885580*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*40786*
Company Tracking Number:	*VPOLCOC.SR.08.AR*		
TOI:	*H20G Group Health - Vision*	*Sub-TOI:*	*H20G.000 Health - Vision*
Product Name:	*Vision Group Blanket Forms*		
Project Name/Number:	*/*		

Attachment "AR07I_NTC_GUARASSOC_AM_CS.doc" is not a PDF document and cannot be reproduced here.

UnitedHealthcare®
A UnitedHealth Group Company

November 3, 2008

Filing Sent Via SERFF

Arkansas Department of Insurance
1200 West Third Street
3rd and Cross
Little Rock, AR 72201-1904

Subject:	Blanket Group Vision Policy	VPOLCOC.SR.08
	Table of Vision Benefits	VTOB.SR.08

Filing For: Group Vision
United HealthCare Insurance Company
NAIC Number: 79413
FEIN Number: 36-2739571

We respectfully submit these forms for your formal approval. These are new forms and are not intended to replace any forms previously filed with the Department.

The forms will be used to provide Blanket Group Accident and Health Vision coverage to college students in your state. The school will be the policyholder.

These materials represent final printed format (with the exception of variable text and corresponding instructions. Please see the following paragraphs for explanation.). Once approved, these forms will be used to support the issuance of our portfolio of group vision products offered in your state.

Explanation of Variable Text
Each form is made up of:

- **Nonvariable Text** that always appears in an issued document.
- **Variable Text** that may or may not appear in an issued document depending on the specific product and plan design selected by the Enrolling Group. Items bracketed in the forms with straight brackets [ ] indicate these items are variable in their content without change in the subject. Changes made to variable text will meet the requirements of your state. Items bracketed with wavy brackets { } indicate these sections are variable by omission. Letters and numbers (excluding form numbers) may be varied. Colons, semicolons, semicolons followed by the word "or" and semicolons followed by the words "and/or" may be omitted. If omitted, a period will be substituted, if necessary. Articles such as "a" and "an" may be substituted as grammatically necessary. Whenever text is bracketed, we have included text that explains the logic of the variable; brackets do not appear in the document issued to a member.

- **Instruction text** provides the logic for when text is included or removed. Please note that instruction text appears only in the filing copy and will not appear in the document issued to a member.

The Policyholder Application-Dental Coverage and Vision Insurance, form number DV-SR-APP (01/2008), was filed with the Dental Forms filing in your state on November 3, 2008. We request your approval to also use this form with the Vision Forms, once it is approved in your state.

If you have any questions or concerns, please contact me at 1-800-232-5432 extension 12234. My mailing address is United HealthCare Insurance Company, PO Box 19032, Green Bay, Wisconsin 54307-9032. My email address is Jayne_S_Jackowski@uhc.com.

Sincerely,

Jayne Jackowski, FLMI, AIRC
Compliance Analyst